OIA 12-9-88

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IN THE SUPREME COURT OF THE STATE OF FLORIDA

LINDA K. PADDOCK,

Petitioner,

v

CHAWALLUR DeVASSY CHACKO, M.D.,

Respondent.

Case No. 72,338

On Discretionary Review From
the District Court of Appeal of Florida
Fifth District
Case No, 86-916

BRIEF OF THE FLORIDA PSYCHIATRIC SOCIETY AND THE FLORIDA DEFENSE LAWYERS ASSOCIATION AS AMICI CURIAE IN SUPPORT OF RESPONDENT

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INTEREST OF AMICI

The Florida Psychiatric Society ("FPS") is a voluntary, non-profit association of medical doctors who specialize in the field of psychiatry in the State of Florida. The FPS, which currently has approximately 700 members, is a District Branch of the American Psychiatric Association, the largest national association of psychiatrists. The FPS seeks to advance the interests of psychiatry in effectively treating persons who suffer from mental illnesses, and has advocated positions on important psychiatric issues before the legislative and executive branches in Florida.

The FPS believes that this case is important to psychiatrists and to the patients they serve. Petitioner urges this Court to adopt a rule that would subject psychiatrists to tort law damages for failing to involuntarily commit patients who reject a recommendation of hospitalization. In the FPS's view, such a rule of liability is both unwarranted and counterproductive. It is based on the implicit assumption that psychiatrists are able to predict dangerous behavior with reasonable accuracy, while the scientific literature is clear that such predictive skills do not exist. The result of adopting such a rule, moreover, will be to undermine the effective therapeutic relationship between psychiatrists and their patients and to increase involuntary hospitalization, often needlessly.

In view of these concerns, the FPS believes that it is appropriate to bring to the Court's attention the available

scientific and clinical literature on the issue of psychiatric ability to predict future violent conduct, including suicide. The FPS further believes that a full discussion of the clinical and legal implications of Petitioner's position would also assist the Court in resolving the instant appeal. Accordingly, this brief is addressed to those matters.

The Florida Defense Lawyers Association ("FDLA") is a voluntary organization composed of attorneys in this State engaged in a civil litigation practice primarily on behalf of defendants. The FDLA's purposes include the improvement of the administration of justice and the support of the adversary system of jurisprudence in the courts of this State. The FDLA is concerned that unwarranted expansions of tort law bring the legal system into disrepute and may also have negative policy implications that are not always apparent to the courts. It thus shares the basic concerns expressed by the FPS and has agreed to support the joint filing of this brief.

STATEMENT OF FACTS

In this brief, amici will rely on the statement of facts contained in the opinion of the Fifth District Court of Appeal from which this appeal is taken. See Paddock v. Chacko, 522 So.2d **410, 411-13** (Fla. 5th DCA **1988).** Although amici are aware that Petitioner disputes that statement of the facts, it is beyond the province of amici to find or assume other facts. In any event, the particular facts of this case do not affect

amici's basic concern that this Court not adopt a rule of law that would allow psychiatrists to be held liable for failing to commit their patients.[1]

INTRODUCTION AND SUMMARY OF ARGUMENT

In amici's view, the issues presented by this case are twofold. The first is whether the existence of a legal duty, enforced in a tort action, is a question of law or a question of fact. Amici take the position that such a question is plainly one of law, not fact, and therefore is properly determined by the court. Amici demonstrate that Petitioner, in arguing that the existence of a duty is a question of fact to be decided by the jury, has confused the general question of whether there is a legal duty with the more particular questions of what the standard of care is and whether it has been breached in circumstances where a duty exists.

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1 Petitioner, in disputing the factual premises of the ruling by the courts below, attempts to redirect this Court's attention to whether Dr. Chacko had a duty to recommend hospitalization in the circumstances of this case, rather than whether he had a duty to involuntarily hospitalize an unconsenting patient. However, because Petitioner raised the question in her Jurisdictional Brief of whether the existence of a duty to commit is a question of law, amici believe that their views are clearly relevant to the issues before this Court. Indeed, Petitioner argues alternatively that if the Court finds that she rejected Dr. Chacko's recommendation to be hospitalized voluntarily, he had a duty "to compel [her] hospitalization." Petitioner's Brief at 27.

The second issue is whether, as a matter of law, psychiatrists have a legal duty to attempt to prevent potentially dangerous patients from committing suicide or other acts of violence by hospitalizing them involuntarily. The facts of this case indicate that the Respondent, Dr. Chacko, advised his patient and her father that she needed continuing psychiatric care and should be hospitalized -- and that his recommendation was rejected. Thus, a decision by this Court finding Dr. Chacko liable for Petitioner's injuries would mean that psychiatrists could be held liable in damages for failing to involuntarily commit all patients who subsequently harm themselves or others.

Amici acknowledge that it is both necessary and proper for psychiatrists to have the discretion to institute involuntary commitment proceedings. But that discretion should not be converted into a legal duty enforceable through tort law damages. The plain, and uncontradicted, fact is that psychiatrists cannot predict future dangerous acts, including suicide, with any reasonable degree of accuracy. As a result, imposition of a duty here would be unfair since the essential medical predicate that would underlie such a duty -- i.e., the ability to predict -- is simply not established.

Such a duty is not only premised on bad medicine, however, it will also lead to bad law and bad policy. To begin with, it would undermine psychiatrists' ability to foster therapeutic relationships with their patients and to provide appropriate treatment. Patients' knowledge that their

psychiatrists are under a legal duty to institute commitment proceedings to protect them from themselves could impede effective therapeutic relationships and deter potentially dangerous individuals from obtaining the therapy they need. At times -- even when it is perfectly appropriate to recommend hospitalization -- if a patient rejects the recommendation it is equally appropriate to respect the patient's wishes and continue outpatient treatment. Such a therapeutic "vote of confidence'' is flatly inconsistent with the duty to commit urged by Petitioner in this case. Indeed, a risk of liability for a failure to commit may even disincline psychiatrists from treating potentially dangerous or suicidal individuals. In these ways, adoption of Petitioner's position could well frustrate the successful treatment of potentially suicidal and other violent patients and thereby exacerbate the very problem that the legal duty would be designed to address.

Finally, holding psychiatrists liable for a failure to commit would also result in unnecessary deprivations of individual liberty. Because psychiatrists are unable to accurately determine which of their many patients will commit violent acts against either themselves or others, they are likely to react to the threat of tort liability by overpredicting violence and undertaking "preventive commitment" in a large number of cases. The increase in unnecessary involuntary hospitalization that will inevitably result from such actions contravenes the express public policy of the Florida Legislature

of employing "the least restrictive means of intervention" in the provision of mental health care. See Fla. Stat. § 394.453(1)(a)(1985). Indeed, because of the importance of this state policy, psychiatrists whose patients prove to have been hospitalized unnecessarily risk tort liability for false imprisonment or malicious prosecution of commitment proceedings. See, e.g., Everett v. Florida Inst. of Technology, 503 So.2d 1382 (Fla. 5th DCA), appeal dismissed 511 So.2d 998 (1987); Pellegrini v. Winter, 476 So.2d 1363 (Fla. 5th DCA 1985). See also Beckham v. Cline, 151 Fla. 481; 10 So.2d 419 (1942).

ARGUMENT

I. WHETHER RESPONDENT HAD A DUTY TO SEEK INVOLUNTARY COMMITMENT FOR PETITIONER IS A LEGAL QUESTION TO BE DETERMINED BY THE COURT, AS CONTRASTED WITH THE FACTUAL QUESTION OF WHETHER AN ESTABLISHED LEGAL DUTY HAS BEEN BREACHED.

Petitioner first argues that the issue of whether a psychiatrist has a "duty" to commit a particular patient is a question of fact to be decided by the jury on the basis of expert opinion. See Petitioner's Brief at 14-16. This argument mistakenly fails to distinguish between two fundamental legal concepts: on the one hand, there is the question of whether an individual has a legal duty to take -- or refrain from taking -- certain steps in certain circumstances; on the other hand, there is the separate question of whether, assuming that such a legal duty exists, the defendant properly discharged it in the case at hand. This latter question is admittedly for the jury to decide,

subject, of course, to appropriate expert testimony. The former question -- in this case whether a psychiatrist may be sued for failing to seek involuntary commitment for a patient -- is equally clearly for the court to decide.

Courts and commentators have long recognized that, regardless of the context, the question of duty is purely a question of law. For example, Professor Prosser states that "the existence of a duty," turns on "whether, upon the facts in evidence, such a relation exists between the parties that the community will impose a legal obligation upon one for the benefit of the other." Prosser & Keeton, The Law of Torts, § 37 at 236 (5th ed. 1984)(citations omitted). Prosser further observes that the existence of a duty "is entirely a question of law, to be determined by reference to the body of statutes, rules, principles and precedents which make up the law; and it must be determined only by the court." Id. Similarly, Restatement (Second) of Torts, § 328B(b) (1965), states that, in an action for negligence, the court determines whether the facts give rise to any legal duty on the part of the defendant.

This basic principle is exemplified by this Court's recent decision in Nova Univ. v. Wagner, 491 So.2d 1116, 1118 (Fla. 1986). In that case, the Court first concluded that a rehabilitation center had a duty to protect its clients from harm. Having done so, the Court then ruled that the issues of

negligence and proximate cause were to be decided by the trier-of-fact.[2] See also Rishel v. Eastern Airlines, 466 So.2d 1136 (Fla. 3d DCA 1985).[3]

In the present case, there is no dispute that psychiatrists generally have a duty to provide appropriate care for their patients. The specific question presented, however, is whether that duty includes an obligation to invoke the special state law provisions regarding involuntary commitment. In this regard, it is important to recognize that the use of involuntary commitment is qualitatively different from other types of medical actions taken by psychiatrists and other physicians. In contrast to recommending hospitalization or the use of medication, commitment involves the invocation of the state's legal machinery to deprive a patient of liberty. The commitment decision, therefore, reflects a state policy concerning the fundamental rights of its citizens. Surely the courts of this state are empowered to decide, as a matter of law, that such an important

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2 Curiously, Petitioner cites Nova Univ. in her brief and discusses the duty imposed on the defendant institution, but fails to note that the question of whether to impose such a duty was decided by the Court. Petitioner's Brief at 15.

3 See Prosser & Keeton, supra at 236:

> A decision by the court that, upon any version of the facts there is no duty, must necessarily result in a judgment for the defendant. A decision that, if certain facts are found to be true, a duty exists, leaves open the . . . question [of the standard of conduct and whether it was breached].

policy should not be undermined or otherwise affected by subjecting psychiatrists to legal damages for a failure to commit. Petitioner's effort to suggest that commitment is like any other medical procedure -- and therefore should be treated simply as a standard of care issue -- thus ignores fundamental legal distinctions and issues of policy.

The authorities relied on by Petitioner provide her with no help. To begin with, Section 768.45(1) of the Florida Statute provides only that, in a malpractice action, the plaintiff must prove that the health care provider's actions breached the standard of care, and describes the standard of care as "that level of care, skill and treatment recognized by a reasonably prudent similar health care provider as being acceptable under similar conditions and circumstances." § 768.45(1). This provision does not even purport to address whether a statutory procedure like commitment may properly be encompassed within a physician's legal duty to his or her patient; rather, it simply describes, in circumstances where the law establishes a duty, how to measure the standard of care that is relevant under that duty.

Petitioner also cites Wale v. Barnes, 278 So.2d 601 (Fla. 1973), for the proposition that courts may not direct verdicts against medical malpractice plaintiffs when there is expert testimony to support a plaintiff's claims. This reliance is likewise misplaced. In particular, there was no issue in that case as to whether the defendants owed plaintiffs a legal duty. The expert testimony in Wale went only to what the standard of

care for obstetricians was and, significantly, involved no state statutory procedure for caring for patients. The issue was thus whether, assuming a legal duty, plaintiffs had introduced sufficient evidence to make out a prima facie case of liability and thereby survive defendants' motion for a directed verdict.

Petitioner further refers to several cases with language suggesting that the existence of a duty is a question appropriate for jury determination. See, e.g., Gooding v. University Hosp. Bldg., 445 So.2d 1015 (Fla. 1984); Hunt v. Palm Springs Gen. Hosp., 352 So.2d 582, 585 (Fla. 3d DCA 1977). In all of these cases, however, the court permitted the jury to determine liability only after it had resolved the underlying question of legal duty. Thus, while the courts may have used the word "duty" in a loose sense, these opinions can hardly be said to stand for the proposition that the legal question of duty is one to be determined by the jury.

In sum, it was for the trial court, the District Court of Appeal, and now this Court to specify whether and under what circumstances, if any, psychiatrists have a duty, subject to tort law liability, to involuntarily commit their patients. This is a legal question to be determined by the courts in light of existing law and the balance it reflects between competing legal and policy considerations. See generally Trianon Park Condominium Ass'n. v. City of Hialeah, 468 So.2d 912, 918 (Fla. 1985), citing Restatement (Second) of Torts § 315 (1965); Ansel, Cohen & Rogovin v. Oberon Inv., N.V., 512 So.2d 192 (Fla. 1987).

II. THE IMPOSITION OF LIABILITY ON PSYCHIATRISTS FOR FAILING ACCURATELY TO PREDICT THEIR PATIENTS' FUTURE DANGEROUSNESS AND TO CONTROL SUCH DANGEROUSNESS THROUGH INVOLUNTARY COMMITMENT IS UNSOUND AS A MATTER OF LAW AND PUBLIC POLICY.

Amici urge this Court to adopt a straightforward holding that psychiatrists are not potentially liable to their patients under Florida law for their failure to commit them involuntarily. Although psychiatrists must be sensitive, and alert, to the risks of suicide and other violent behavior posed by their patients -- and undertake to assess those risks and develop treatment options accordingly, including involuntary commitment where appropriate -- the decision to seek a patient's commitment must flow from the psychiatrist's exercise of professional discretion, and **not** from the threat of tort law damages for failure to do so. The imposition of a duty to commit, as Petitioner seeks, in lieu of recognition of the treating psychiatrist's discretion to commit, will necessarily result in psychiatrists seeking the involuntary commitment of large numbers of patients -- notwithstanding their clinical judgments that commitment is unwarranted, or worse, therapeutically counterproductive -- solely to avoid future tort liability.[4]

Petitioner's suggested approach is both an ineffectual and undesirable means of dealing with the problem of violent or

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[4] Although the instant case concerns a patient who injured herself, the same legal principles regarding a duty to commit are likely to govern cases involving patients who inflict harm on others as well. Accordingly, amici discuss both types of situations in this brief.

suicidal actions by the mentally disabled because: (a) psychiatrists are unable to effectively predict violent behavior; thus, the imposition of a duty to commit, which necessarily must be premised on such predictions, imposes unfair and unworkable obligations on psychiatrists; (b) the imposition of a duty to commit tends to undermine a psychiatrist's ability to provide effective and therapeutic psychiatric care for those individuals who most need it; and (c) such a duty risks the unnecessary deprivation of patient liberty in a significant number of cases, thereby frustrating important policies expressed by the Legislature of the State of Florida.

A. Because Psychiatrists Cannot Predict Violent Behavior with a Reasonable Degree of Accuracy, Imposition of Tort Liability When They Fail to Commit Based on Such Predictions is Unwarranted and Unsound as a Matter of Policy.

The difficulties inherent in psychiatrists' efforts to predict their patients' dangerousness have been recognized by many courts.[5] Although psychiatrists may be able to recognize and assess violent or suicidal tendencies in their patients, accurate prediction of the ultimate act -- i.e., that these

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5 **See,** e.g., Barefoot v. Estelle, 463 U.S. 880, 899, n.7 (1983); White v. United States, 244 F. Supp. 127, 131 (E.D. Va. 1965), aff'd, 359 F.2d 989 (4th Cir. 1966) (hospital not negligent when it failed to guard patient who escaped and stood in front of train); Tarasoff v. Regents of University of California, 13 Cal.3d 177, 529 P.2d 553, 118 Cal. Rptr. 129 (1974), vacated, 17 Cal.3d 425. 551 P.2d 334, 131 Cal. Rptr. 14 (1976). See also Barefoot v. Estelle, 463 U.S. at 921 & n.2 (Blackmun, J., dissenting); Dillmann v. Hellman, 283 So.2d 388 (Fla. 2d DCA 1973).

tendencies will actually result in violence -- remains an elusive goal. The imposition of a duty to accurately predict patient violence and to institute commitment proceedings based on those predictions thus requires psychiatrists to do the impossible. More significantly, because of their inability to make such predictions, psychiatrists will overpredict, and feel compelled to institute commitment proceedings against many of their patients for whom, in their clinical judgment, commitment is unnecessary or otherwise medically inappropriate. In short, the pressures generated by the need to make accurate predictions in this environment will inevitably lead to overprediction and overcommitment.

Psychiatrists, social scientists, and legal commentators are overwhelmingly in agreement that violence, including suicide, cannot be predicted with any acceptable degree of reliability or validity.[6] The consistent research finding is that psychiatrists and other clinicians fail to accurately predict whether a patient will be violent in at least two out of three cases,[7] and that

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6 "Reliability" refers to the degree of correlation or correspondence of judgment between professionals using the same method. Thus if representative pairs of psychiatrists, interviewing a representative sample of prospective patients, usually agree that each individual is or is not "dangerous," the judgment of "dangerousness" is said to be reliable. "Validity," by contrast, refers to how accurate the judgment in question is, without regard to the likelihood of agreement among psychiatrists as to that judgment.

7 See, e.g., Janofsky, Spears & Neubauer, Psychiatrists' Accuracy in Predictins Violent Bahavior on an Inpatient Unit, 39 Hospital and Community Psychiatry 1090 (1988) ("[r]ecent research demonstrates that psychiatrists' accuracy in predicting violent behavior rarely exceeds results obtained by chance alone."); Steadman, Predicting Dangerousness Amons the Mentally Ill, 6 Int'l. J. Law & Psychiatry 381-90 (1983); J. Monahan, The Clinical Prediction of Violent Behavior (1981); Ennis & Litwack,

there is no consistent professional standard for predicting violence.[8] In short, scientific studies clearly demonstrate that predictions of dangerousness of mentally disabled persons are extremely inaccurate and are largely based on speculation.[9]

Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom, 62 Cal. L. Rev. 693, 713 (1974) (hereafter Flipping Coins); Kozol, Boucher, & Garofalo, The Diagnosis and Treatment of Danserousness, 18 Crime & Delinquency 371 (1972). See also Monahan, The Prediction of Violent Behavior: Toward a Second Generation of Theory and Policy, 141 Am. J. Psychiatry 10, 11 (1984). The sole exception to this well-established conclusion involves instances where a patient has actually begun to act out violent tendencies. In those circumstances, it appears that psychiatrists may be able to accurately predict that violence will in fact result in 50-60% of such cases. See McNeil & Binder, Predictive Validity of Judsments of Danserousness in Emergency Civil Commitment, 144 Amer. J. Psychiatry 197 (1987). In the instant case, of course, there is no claim that Petitioner was acting out her suicidal thoughts or ideation at the time that she was in Dr. Chacko's care.

8 See Steadman, The Right Not To Be a False Positive: Problems in the Application of the Dangerousness Standard, 52 Psychiatric Quarterly 84, 96 (1980) ("Nowhere in the research literature is there any documentation that clinicians can predict dangerous behavior beyond the level of chance."). See also Wenk, Robinson & Smith, Can Violence Be Predicted?, 18 Crime & Delinquency 393, 394 (1972) (finding it impossible to identify any subclass of offenders "whose members have a greater-than-even chance of engaging again in an assaultive act.").

9 See J. Monahan, The Clinical Prediction of Violent Behavior (1981); B. Ennis & R. Emery, The Rights of Mental Patients 20 (1978); Morse, Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law, 51 S. Cal. L. Rev. 527 (1978); Report of the American Psychological Association Task Force on the Role of Psychology in the Criminal Justice System, 33 *Am.* Psychology 1099 (1978); Steadman, Predictins Dangerousness Amons the Mentally Ill, 6 Int'l. J. Law & Psychiatry 381-90 (1983); American Psychiatric Association Task Force Report, Clinical Aspects of the Violent Individual 28 (1974) (90 per cent error rate "unfortunately . . . is the state of the art"). See generally D. Shapiro, Psychological Evaluation and Expert Testimony (1984); Wettstein, The Prediction of Violent Behavior And The Duty To Protect Third Parties, 2 Beh. Sciences and the Law 291 (1984); Scott, Violence in Prisoners and Patients, Medical Care of Prisoner And Detainees, 123 U. Pa. L. Rev. 439 (1975); Flipping Coins, supra note 7 at 750-51; Rector, Who Are the Danserous? Bull. Am. Acad. Psych. & L. 186 (July 1973); Rosenhan, On Being Sane in Insane Places, 13 Santa Clara L. Rev. 379 (1973); Justice

The American Psychiatric Association's Task Force on Clinical Aspects of the Violent Individual **(1974)** (hereafter Task Force) concluded after exhaustive review of the literature that judgments concerning the potential for future violence and the "dangerousness" of a given individual are "fundamentally of very low reliability[,]" and validity **(90%** error rate). Task Force at **23, 30.** The Task Force found that efforts to predict violence of particular individuals resulted in an unacceptably high rate of "false positives" -- i.e., violent behavior was predicted for individuals who did not demonstrate any violence within the period of study. Id. at **23-24.**[10] Subsequent research confirms

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& Birkman, An Effort to Distinguish the Violent from the Nonviolent, 65 So. Med. J. **703 (1972);** Kozol, Boucher & Garofalo, The Diagnosis and Treatment of Dangerousness, **18** Crime & Delinquency **371 (1972);** Rubin, Prediction of Dangerousness in Mentally Ill Criminals, **27** Arch. Gen. Psychiatry **397 (1972);** United States Department of Health Education and Welfare, HEW NEWS (News Release August **8, 1974).**

10 This tendency to overpredict violence results not only from the difficulty of identifying factors that suggest future violence but also from the extremely low incidence of violence as a societal phenomenon:

> Predictions of dangerousness, like those of suicide, are, with few exceptions, predictions of rare or infrequent events . . . . This means that even if the characteristics of such future violent patients could be specified with fairly great accuracy, predictions based upon such characteristics will identify far more "false positives" than "true positives."

Task Force at **23-24.** Steadman & Cocozza report similar "overprediction" tendencies:

> Because psychiatrists cannot accurately predict who will become violent, they frequently err. Rather than random errors, however, their inaccurate predictions are consistently on the safe side. They overpredict. They assume that since some

the Task Force findings.**11**

These findings are equally applicable to .he subgroup of violent patients who are potentially suicidal:

> No psychologic or physiologic tests have been shown to enhance the predictability of suicide. Compounding the problem is the fact that suicide is statistically rare considering the vast numbers of people potentially at risk, and predictability of an uncommon event is complicated by the statistical artifact of false positives.

Perr, Suicide Liability: A Clinical Perspective, **1** Legal Aspects of Psych. Practice **2** (Oct. **1984).**[12]

> patients are dangerous, the one under consideration might be. The result of this practice is that as many as twenty harmless persons are incarcerated for every one who will commit a violent act.

Steadman & Cocozza, Stimulus/Response: We Can't Predict Who is Danserous, **8** Psych. Today **32**, **35** (Jan. **1975).**

11 See, e.g., Janofsy, Spears & Neubauer, Psychiatrists' Accuracy in Predicting Violent Bahavior on an Inpatient Unit, **39** Hospital and Community Psychiatry **1090-94 (1988);** J. Monahan, The Clinical Prediction of Violent Behavior **(1981)** (hereafter Clinical Prediction); See, e.g., Schwitzgebel, Prediction of Danserousness and its Implications for Treatment in Modern Legal Medicine, Psychiatry, and Forensic Medicine **784** (W. Curran, A. McGarry & C. Petty, eds. **1980);** Steadman & Cocozza, Psychiatry, Danserousness, and the Repetitively Violent Offender **69** J. Crim. Law & Criminology **226 (1978).** See generally supra note 9.

12 See also Fawcett, Scheftner, Clark, Hedeker, Gibbons & Coryell, Clinical Predictors of Suicide in Patients with Major Affective Disorders: A Controlled Prospective Study, **144** Am. J. Psychiatry **35-40 (1987);** Goldney & Spence, Is Suicide Predictable?, **21** Australian and New Zealand J. of Psychiatry **3-4 (1987);** Murphy, The Physician's Role in Suicide Prevention, in Suicide **171** (A. Roy. ed. **1986);** Pokorny, Prediction of Suicide in Psychiatric Patients, **40** Arch. Gen. Psychiatry **249 (1983);** Murphy, On Suicide Prevention and Prediction, **40** Arch. Gen. Psychiatry **343 (1983);** Perr, Lesal Aspects of Suicide, J. Legal Medicine (Jan. **1978).**

The notion that psychiatrists have expertise in predicting their patients' suicidal or other violent conduct is based largely on popularly-held stereotypes that mentally disordered individuals are more likely than is the general population to engage in such conduct and that the presence of a mental disorder, per se, makes the prediction of such acts easier and more accurate than would otherwise be the case. There is no empirical support for these propositions, however. See D. Shapiro, Psycholosical Evaluation and Expert Testimony, supra at **157-160.**[13] Although some data suggest a higher correlation between the existence of certain mental disorders and violence directed towards oneself, even among psychiatric patients who have been hospitalized because of a depressive or suicidal state existing studies demonstrate "the unlikelihood of one's ever being able to make accurate predictions of suicide in the population." Murphy, The Physician's Role in Suicidal Prevention, supra at **177-78.**[14]

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13 See also Flipping Coins, supra note **7** at **716** (and citations contained therein). Indeed, Professor Monahan has observed that "[t]he most relevant noncorrelate of violence is 'mental illness'." Clinical Prediction, supra at **77** (emphasis added).

14 See also Goldney & Spence, Is Suicide Predictable, **21** Austraillian and New Zealand J. Psychiatry 3-4 **(1987);** Pokornv, Prediction of Suicide in Psychiatric Patients, 40 Arch. Gen. Psychiatry **249-57 (1983);** Murphy, On Suicide Prediction and Prevention, 40 Arch. Gen. Psychiatry **343-44 (1983);** Motto, Suicide Risk Factors in Alcohol Abuse, **10** Suicide Life Threat Behav. **230-38 (1980);** Motto, The Psychopathology of Suicide: A Clinical Model Approach, **136** Am. J. Psychiatry **516-20 (1979);** Perr, Liability of Hospital and Psychiatrist in Suicide, **122** Am. J. Psychiatry **631 (1965);** Rosen, Detection of Suicidal Patients: An Example of Some Limitations in the Prediction of Infrequent Events, **18** J. Consulting Psychology **397-403 (1954).**

The difficulty in predicting suicide is attributable as much to its relatively infrequent occurrence as to the highly complex and difficult task of making such a prediction. A leading psychiatrist in the field has explained:

> Suicidal risk is not a diagnosis. It is an act or potential act that may be associated with a psychiatric disorder and compounded by environmental and life circumstances. Successful treatment of psychiatric disorder may lessen the risk, but since there is no clear-cut correlation between current disease and ultimate suicide, treatment of the disease does not permanently preclude suicide.

Perr, Suicide Liability, supra at 5.[15] Even prior suicide

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15 In discussing the difficulties inherent in assessing the degree of patients' risk for suicide, Dr. Perr notes:

> While depressed people, particularly those with psychotic depressions, are generally more likely to commit suicide, few actually kill themselves. Almost everyone has depressed feelings at one time or another. Anxiety and depression as descriptive states are almost ubiquitous in psychiatric patients as well as in a large proportion of the population. A large part of the population has considered suicide at one time or another -- somewhere between 8 and 20%.
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> Statistical, social, and psychiatric factors do not take into account the fact that people interact in a fluid manner with the world. Therefore, the usual but potential stresses and disappointments in living cannot be predicted any more than a future establishment of a good relationship, adequate sex life, or satisfactory job can be. Similarly, all psychiatric conditions fluctuate both with and without treatment and are subject to a multiplicity of determinants.
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> Thus, suicide is a pervasive human risk and may occur under a wide variety of circumstances.

attempts may not be helpful indicators of suicide risk, if these attempts or gestures were by labile (e.g., histrionic, passive-aggressive or antisocial) personalities. Id. at 6. In sum, "[t]he conclusion is inescapable that [psychiatrists] do not possess any item of information or any combination of items that permit [them] to identify to a useful degree the particular persons who will commit suicide, in spite of the fact that [they] do have scores of items available, each of which is significantly related to suicide." Pokorny, Prediction of Suicide in Psychiatric Patients, supra, at 257.[16]

In view of this well-established body of research, adoption by this Court of the duty that Petitioner seeks to impose on psychiatrists would unfairly penalize them for failing to perform a function that they are incapable of performing. As

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Perr, Legal Aspects of Suicide, supra at 4.

16 See also Pallis, Gibbons & Pierce, Estimating Suicide Risk Among Attempted Suicides, 114 Brit. J. Psychiatry 139, 147 (1984) (emphasis added):

> A perennial theme in discussing the clinical use of [predictors] is the rather poor level of accuracy. Indeed, the low rate of [actual suicides] makes "suicide prediction" a contradiction in terms: one who safely predicts that no one will commit suicide can expect to be correct most of the time, even as regards those attempters placed at high levels of risk!

noted above, although psychiatrists are capable of recognizing and assessing suicidal or other violent "tendencies" in their patients, that is a far cry from predicting which of their many patients with such tendencies will actually commit suicidal or other acts of violence. In order to provide effective treatment for their patients, psychiatrists must have the flexibility to choose from among a variety of treatment options, including involuntary hospitalization, those which they believe will be most therapeutic for their patients. Such a choice is a delicate one, informed by the psychiatrist's professional training and clinical judgment, and should not be forced -- indeed eclipsed -- by the threat of liability for the failure to commit a patient who ultimately proves to be suicidal or violent. Should this Court adopt Petitioner's view, psychiatrists could not -- save perhaps by seeking commitment for all who exhibit the slightest urge to harm themselves -- conduct their professional affairs in a way that assures protection from substantial tort liability. The tort law of the State of Florida should not be extended to create a situation so fundamentally unfair for psychiatrists who attempt to treat difficult patients suffering from severe mental disorders.

B. Allowing Psychiatrists to be Sued for Failing to Commit Patients Who Harm Themselves Would Ill-Serve The Policy Goal of Effective Psychiatric Care for the Mentally Disabled.

An effort to invoke the tort law as a means of requiring psychiatrists to accurately predict their patients'

dangerousness, and based on those predictions to institute involuntary commitment proceedings, is doubtless motivated by a desire to protect those individuals and the public from the random or calculated violence of mentally disturbed persons. Unfortunately, for several reasons, such a legal rule is likely to be counterproductive in terms of these very goals. If anything, the rule proposed by Petitioner would tend to undermine the likelihood of effective treatment for potentially dangerous persons.

Because, as noted above, psychiatrists are not able to accurately predict dangerous behavior by their patients, psychiatrists treating potentially suicidal or other dangerous patients will, under Petitioner's approach, be left with few, if any, courses of action to protect themselves from exposure to severe tort liability. They will reasonably assume that, in the event of a lawsuit, the dangerousness of a particular patient who has committed a violent act will seem obvious. With the benefit of hindsight, a court or jury is not likely to be moved by abstract protestations about the difficulties of prediction. Nor will it do much good to describe the many other patients with comparable "violent" or "suicidal" tendencies who have not carried out these acts and, indeed, have in many instances been stabilized and integrated successfully into society. Once a suicide or other violent act has been attempted or committed there will be an almost irresistible temptation in the legal

system to conclude that the psychiatrist should have involuntarily hospitalized the patient.

Faced with such a prospect, one rational response for psychiatrists is to avoid altogether the patients who pose these kinds of risks. The position proposed by Petitioner, therefore, may discourage psychiatrists from treating patients whose history or behavior suggests that future suicidal or other violent acts are a possibility. In fact, even without such a rule, many psychiatrists already seek to avoid potentially violent patients because they are notoriously difficult to treat.[17] If psychiatrists are now told that they may be held responsible for their patients' violent conduct -- despite their acknowledged inability to predict that conduct -- they will be even more reluctant to begin treatment. This, in turn, may lead to less care for the very patients who may need psychiatric help the most.

Holding psychiatrists liable for a failure to commit will also undermine effective treatment in other ways. One crucial concern is that such a rule would seriously interfere with the development of an effective therapeutic treatment relationship between the psychiatrist and the patient. Effective psychotherapy requires that patients be able to reveal their innermost thoughts and feelings, secure in the knowledge that

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17 See Stone, The Tarasoff Decision: Suing Psychotherapists to Safeguard Society, 90 Har. L. Rev. 358 (1976).

those thoughts and feelings -- including violent impulses -- will be received without the psychiatrist rushing to commit the patient or otherwise reacting in a manner that discourages their disclosure. Thus, if psychiatrists are effectively forced to commit patients who exhibit almost any suicidal or other violent tendencies, they will be sorely hindered in their efforts to develop a trusting and supportive environment in which to treat such patients. See Currie v. United States, 836 F.2d 209, 213 (4th Cir. 1987).18

Moreover, the breach of trust that a duty to commit tends to foster will not only be painful for patients but may precipitate serious collateral harms as well. Faced with an increased likelihood of commitment, at least some patients will probably avoid treatment altogether or avoid making the very statements during treatment that may be most essential to their recovery.[19] Such reticence, in turn, may well increase the

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18 It is also possible that a psychiatrist faced with a duty to commit will attempt commitment only to find that the court refuses to approve it. In such circumstances there is an additional risk that a patient will respond to the attempt to commit by withdrawing from treatment altogether.

19 These dangers are not speculative. In a survey of California psychiatrists and other clinicians by the Stanford Law Review, a majority of those surveyed thought that patients would withhold information important to treatment if they believed the therapist might breach confidentiality, or commit them. Note, Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of Tarasoff, 31 Stan. L. Rev. 165, 183 (1978)(hereafter Stanford Note). And fully one-fourth of the respondents "reported actually observing their patients' reluctance to discuss their violent tendencies when informed of [such possibilities.]" Id.

likelihood that patients will "act out" the violent impulses that they are afraid to expose and resolve in therapy. Thus, the imposition of such a duty by the Court could jeopardize the treatment process itself.[20]

To be sure, amici do not suggest that commitment by a psychiatrist is never appropriate. There are times when the benefits of voluntary treatment are simply outweighed by the exigencies presented in a particular situation. As a result, the State of Florida properly authorizes psychiatrists, other clinicians, law enforcement officers or any other individual to initiate proceedings to involuntarily examine[21] and place in a treatment facility[22] mentally ill persons who meet the statutory standards under the Baker Act, Fla. Stat. §§ 394.451 et seq. But the question here is not whether psychiatrists *may* institute involuntary commitment proceedings when, in their professional judgment, it is appropriate to do so, but whether they must do so

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20 There is a serious question in the profession "whether involuntary hospitalization does in fact prevent eventual suicide and whether the hospitalization procedure itself might be quite harmful and misused." Perr, Suicide and Civil Litigation, 19 J. Forensic Sciences 261, 262 (1974). Recent trends in the treatment of potentially suicidal patients "do not stress the use of hospitalization, voluntary or involuntary. Rather, emphasis is laid on person-to-person contact and continued sympathetic support for the individual." Id.

21 Fla. Stat. § 394.463.

22 Fla. Stat. § 394.467.

upon a pain of tort damages.[23] The certain result of adopting Petitioner's view will be a dramatic increase in commitment proceedings motivated, not by the clinical judgment of psychiatrists, but by their fear of being second-guessed in a later tort suit.

The risk of damaging the therapeutic relationship might be worth taking if there were reason to believe that the net effect of imposing a broad duty would be a significant prevention of suicide or other violent actions by psychiatric patients. But, even if psychiatrists were better able to predict dangerous conduct in their patients, it is far from clear that a duty to commit would advance that objective. In many cases, other options are obviously far preferable. Indeed, "[m]ost patients will tolerate a variety of other protective forms of crisis intervention by the therapist with much less damage to the therapeutic alliance and with much less rage towards . . . the therapist . . . because their psychological implications are much less sinister to the patient." Stone, The Tarasoff Decision: Suing Psychotherapists to Safesuard Society, supra note 17, at 370-71. Thus, while involuntary hospitalization may lessen the immediacy of a suicidal occurrence, it may not be the best approach to the underlying psychiatric problem or to dealing with

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23 Stanford Note, supra at 190 (distinguishing the effects of "discretionary" disclosures from the effects of a legal duty to warn).

the patient's long-term ability to avoid suicide and to live a productive life. See Perr, Suicide and Civil Litigation, supra, at 262.

In sum, a clinical decision about how best to respond to a patient's intimations of suicidal intention is often complex and difficult. Under the approach followed by the courts below, psychiatrists can decide on a case-by-case basis whether a given threat is serious enough to justify a deprivation of liberty, and whether involuntary commitment is likely to improve matters or make them worse. Were this Court to allow psychiatrists to be sued for failing to commit their patients, however, the likely result would be a large number of involuntary commitments motivated primarily by the risk of tort liability. Such a result serves no good purpose and thwarts the possibility of effective therapy for the very patients whose potential violent conduct the rule would be designed to prevent.

C. Holding Psychiatrists Liable for Failing To Commit Their Patients Would Result in the Unnecessary Deprivation of Liberty in Significant Numbers of Cases.

Because psychiatrists cannot identify which of their nany patients with potential violent tendencies will actually resort to suicide or other violence, the only rational response to this lack of knowledge, in the face of the threat of liability posed by a duty to commit such as that advanced by Petitioner, is to assume that every patient who expresses violent or suicidal emotions will act on those emotions. As a result, psychiatrists

will vastly overpredict violence, and will institute commitment proceedings against many patients whom, absent such a duty, they would continue to treat on an outpatient basis or work with in an effort to encourage voluntary hospitalization. Thus, the major impact of converting involuntary commitment from a discretionary decision to one that is subject to a damages action is likely to fall on the patients themselves. It is they who will be confined in psychiatric hospitals despite their psychiatrist's clinical judgment that hospitalization is probably unnecessary or even undesirable.[24]

It follows, therefore, that a decision exposing psychiatrists to liability for a failure to commit would significantly alter the existing balance between two competing values: the value of preventing individuals from harming themselves or others, and the value of allowing many mentally ill persons to receive appropriate treatment on a voluntary basis. Even assuming that such a rule would lead to less violence by mentally ill patients -- an assumption that we think is questionable at best -- this result would come at the expense of

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24 See generally Washington Post, Aug. 3, 1987, A-1, Column 1 (noting trend of therapists responding to concerns over liability by recommending longer hospital stays, refusing to treat violent or suicidal patients, and in some cases ordering unnecessary medical tests to rule out physical problems); Perr, Suicide and Civil Litigation, supra.

needlessly hospitalizing many, many patients who would not in fact commit such violence.[25]

By restricting involuntary commitment to cases where there is "clear and convincing" evidence of dangerousness to self or others, the State of Florida has struck the balance between individual liberty and the protection of such individuals and society at large in a manner that strongly favors voluntary and, where possible, outpatient treatment of the mentally ill in cases of doubt. In enacting the Baker Act, moreover, the State Legislature expressed its intent that "the least restrictive means of intervention be employed based on the individual needs of each patient . . . ." Fla. Stat. § 394.53(1)(a). Indeed, Florida law permits involuntary commitment only upon clear and convincing evidence, inter alia, that "[a]ll available less restrictive treatment alternatives...have been judged to be inappropriate." § 394.467(1)(b). See In re Smith, 342 So.2d 491 (Fla. 1977); In re Beverly, 342 So.2d 481 (Fla. 1977). Yet the authorization by this Court of tort law exposure for a failure to commit would contravene this State policy because it would force psychiatrists to "indulge every presumption in favor of . . . restraint, out of fear of being sued." Sherrill v. Wilson, 653 S.W.2d 661, 664 (Mo. 1983). See also Cairl v. State, 323 N.W. 2d 20, 23 n.3 (Minn. 1982).

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25 The effect of such an approach would also be to impose significant additional financial burdens as well since the cost of a dramatic increase in the use of involuntary hospitalization would obviously be great.

Although the major impact of establishing a duty to commit would fall on the large numbers of psychiatric patients who will be hospitalized unnecessarily or inappropriately, the adoption of such a rule would also lead to difficult professional and legal dilemmas for psychiatrists as well. To support involuntary commitment in this State, a psychiatrist must be prepared to testify that there is a "substantial likelihood that in the near future" the patient "will inflict serious bodily harm on himself or another person." Fla. Stat. § 394.467(1)(a)2.b. Plainly, in making that determination, psychiatrists should be guided only by their best professional judgment and the needs of their patients. But if psychiatrists can be held liable for failure to commit, a new consideration -- avoiding potential liability -- is also likely to bear on their decisionmaking process. Although that is certainly an unfortunate consequence, it is nevertheless the inevitable, indeed, the intended, consequence of allowing tort law actions for a failure to commit.

It is also necessary to realize that a psychiatrist who improperly commits a patient faces potential legal exposure on that ground as well. The liberty interest of individuals subject to involuntary commitment is constitutionally protected,[26] and the wrongful deprivation of such individuals' liberty has long been recognized in this jurisdiction as legally actionable. Alexander v. Alexander, 229 F.2d 111 (4th Cir. 1956)(pre-Baker

26 See O'Conner v. Donaldson, 422 U.S. 563 (1975).

Act Florida law authorizes suits for malicious prosecution against persons initiating commitment proceedings maliciously and without probable cause); Beckham v. Cline, 151 Fla. 481, 10 So.2d 419 (1942); Everett v. Florida Inst. of Technology, 503 So.2d 1382 (Fla. 5th DCA), appeal dismissed 511 So.2d 998 (1987)(liability for false imprisonment for failure to comply with Baker Act procedures); Pellegrini v. Winter, 476 So.2d 1363 (Fla. 5th DCA 1985). See generally Meredith v. McNeal, 308 So.2d 179 (Fla. 1st DCA 1975). As a result, the imposition of a duty to commit would require psychiatrists to navigate an exceptionally narrow path between competing spectres of tort liability when making the extraordinarily complex and delicate judgments required of them regarding their patient's suicidality or potential violence.

For these reasons, amici believe that adoption of the rule proposed by Petitioner would have significant negative effects that would greatly overwhelm any positive effects that might be anticipated. Aside from the enormous difficulties it would create for psychiatrists, such a rule would also greatly disserve patients. It would do so, inter alia, by dramatically increasing the pressure to invoke involuntary commitment procedures. At a minimum, if such a fundamental change in state policy is to be effected, it should be done by the legislature, which can fully assess the competing concerns and can also ensure that necessary resources are available to provide for those who are committed as a result of this new rule of tort law liability.

In the absence of such a legislative directive, this Court should not allow psychiatrists to be held liable for failing to commit their patients.

CONCLUSION

The judgment of the District Court of Appeal should be affirmed.

Respectfully submitted,

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